

The management of childhood diabetes needs to focus not only on glycaemic control but also on efforts to prevent excessive weight gain and to reduce other cardiovascular risk factors.

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ESPE/LWPES Consensus Statement on diabetic ketoacidosis in children and adolescents (*Arch Dis Child* 2004;**89**:188–94)

Given the fact that patients with type 1 diabetes have a life-long predisposition to recurrences of diabetic ketoacidosis, it is remarkable that the approach to the management of this complication is taught in a fundamentally different way in paediatrics and in adult medicine. In the former, the primary aim is to eliminate ketonaemia and ketonuria expeditiously, using a fixed dose and evidence based insulin infusion, namely, 0.1 unit/kg/h,¹ which is maintained as long as necessary even if it entails the risk of hypoglycaemia, the latter eventuality being circumvented through the infusion of intravenous glucose, given the fact that the resolution of acidaemia takes longer than the normalisation of blood glucose concentrations.²

The teaching in adult medicine, conveyed through the medium of the handbook most likely to be used by junior doctors, is that normalisation of blood glucose is paramount, hence the preoccupation with a sliding scale insulin regime targeted at the blood glucose,³ as opposed to a fixed dose regime targeted at ketonaemia and ketonuria.

What this means is that, in the transition from childhood to adulthood, a diabetic will encounter a change in emphasis during the management of recurrences of ketoacidosis. I am not sure that this is right.

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Soy formulas and hypothyroidism

We were interested in a recently published article in *Archives* by Conrad and colleagues.¹ They concluded that infants fed soy formula had a prolonged increase of thyroid stimulating hormone when compared to infants fed by non-soy formula. We have some criticisms of their study methods.

In this retrospective study there was a notable difference between the patient numbers in the soy diet group (n = 8) and non-soy diet group (n = 70). It is well known that in prospective studies in which data of two groups are compared, in order to gain statistically significant results there should be a minimum of 10 test subjects in each group and the numbers in the groups should be close. Although it is not essential to follow this rule in retrospective studies like the one of Conrad *et al*, the statistical reliance of the study fails since the soy diet group has eight patients whereas the other one has 70.

Secondly, in studies in which comparisons of any of body fluid parameters are made for each group, for better results, it is important that the materials must be studied in the same sessions using calibrated machines after the materials have been stored appropriately. This could not be achieved since the study was retrospective, and it is therefore inevitable that there were differences between the thyroid stimulating hormone and thyroxine results of the soy diet and non-soy diet groups. For these two reasons we think it is impossible to conclude that soy formula decreases the success of treatment in congenital hypothyroidism. We believe that further prospective controlled studies can better shed light on this topic.

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Evidence based guideline for post-seizure management

Following the publication of the guideline review “Evidence based guideline for post-seizure management in children presenting acutely to secondary care”¹ we would like to clarify the following.

First, the guideline is published in its original algorithm format in a peer reviewed journal² as well as being available on the PIER website (www.pier.shef.ac.uk), complete with minor changes following the updated systematic review in 2002.

Second, the guideline was not published until it had been assessed with regard to ease of use and clinical impact. The findings of this large scale field study show its effectiveness in improvements in quality of care and are also published.³

Third, the original guideline was developed by The Paediatric Accident & Emergency Research Group, and represents many years of work. The individuals and affiliations at the time of the research are as follows:

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Ethics; the third dimension

In essence, ethics provide the guidelines for civilised human interaction. It is an evolving concept, but through the ages some accepted ethical principles crystallised. The first crude definition focused on the individual's responsibility towards his community, prioritising the interests of the community. However, the events preceding the French revolution and the brutality of the two world wars emphasised the need to protect individuals and minority groups against abuses of power. The ethical focus shifted from individual responsibility towards the protection of individual human rights. With the swing of the pendulum, individual rights were often protected to the detriment of the larger community.

In medicine the same shift in emphasis forced the current ethical debate on the delicate balance between the interests of the individual and that of the community, especially in resource limited settings. The reality of the third millennium is that all the world's inhabitants are essentially part of the same global community. The two dimensional balance between the individual and the community need to reflect this global ethical responsibility.

The third millennium also confronts us with the neglected third dimension of our ethical responsibility. It is not only the interests of the individual versus that of the community that